Asthma Care Plan

Child's Name ______________________________ Birth Date _________________________

What is asthma?

How does the asthma affect the Child?

What special needs does the child have associated with asthma?

What will Head Start Staff need to be aware of?

What medication does child take, if any, for the asthma and will they need to be given at Head Start?

Parents Signature ___________________________________ Date ____________________________

Health Care Professional _____________________________ Date ____________________________

Head Start Supervisor ________________________________ Date ____________________________

The Following Individuals Were Present for Asthma Care Plan Meeting

Date _________________

Name	**Title**